Differing Attitudes Between Psychiatrists and Primary Care Providers at the Interface

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Abstract

Objective: Market forces caused by managed care are shaping practice styles for both psychiatrists and primary care physicians. This study offers a sample of the attitudes of both groups of practitioners highlighting the differences. Method: Forty-two psychiatrists and primary care physicians (PCP) completed surveys. The responses of each group were compared using chi square analyses. Results: Psychiatrists and PCPs differed significantly on their: 1) degree of comfort in the other's traditional service domain - with PCPs more comfortable dealing with their patients' psychiatric problems than psychiatrists were dealing with their patients' medical problems, 2) perceived barriers to effective communication- psychiatrists acknowledge their own time constraints while PCPs blame their colleagues unavailability (actually an agreement that psychiatrists' availability is a limiting factor), 3) projected areas of interface in the future- with psychiatrists prioritizing collaboration on health maintenance while PCPs valued collaboration on prevention and referral as equally significant. Conclusions: Conflict between needs and expectations found in this pilot study, if shown in larger studies to be representative, will impact the success of changes in practice patterns encouraged by emerging managed care initiatives. These findings suggest that the discordant expectations between psychiatrists and PCPs about the interface of their practices deserve further study.

Recent changes in the healthcare delivery system have focused attention on the changing practice patterns between psychiatry and primary care, with some crossing-over into each other's service domain.[1,2] Though external forces may ultimately dictate the roles of the generalist and specialist, attitudes about the scope of practice among active practitioners and existing patterns of interaction between the groups will certainly impact the success of such mandates. Primary care's current role in mental health care delivery has been characterized as de facto responsibility for 50% of the nation's mentally ill population. Unfortunately the literature documents an inadequate record for appropriate diagnosis and treatment of mental disorders such as major depression.[3] Concerning their interaction with psychiatrists, PCPs have complained about psychiatrist's unavailability and unsatisfactory feedback on referrals.[4]

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The state of medical care in psychiatric practice is also of concern. Studies have shown that half of outpatient psychiatric patients report medical problems while less than half of patients' significant physical disorders are recognized by psychiatrists.[5] Recent reviews have looked at the advantages and disadvantages of psychiatrists providing primary care for psychiatric patients.[6] In regards to their relation to PCPs, psychiatrists have historically considered their role to be one of educator and consultant to their generalist colleagues,[7] but have been shown to be less than successful in this endeavor.[2]

As external and internal factors shape the evolution of roles for both psychiatrists and generalists, existing literature notes that patterns of interaction between these groups are influenced by the individual practitioner's perceptions and intentions.[7] In an effort to learn more about current perceptions that generalists and specialists have towards each other, a survey was designed to examine the following issues: 1) degree of comfort in treating problems in the other group's service domain 2) perceived amount, quality and impediments to communication, and 3) preferred future directions for interfacing, (such as the role for mental health screening instruments and treatment algorithms). To our knowledge a formal assessment of practitioner attitudes on these topics has not previously been published.

Method

Subjects

The focus for this study was a recent conference (6/97) held in Honolulu, Hawaii on new advances in pharmacotherapy of depression. The morning session was geared for psychiatrists and the afternoon session was designed forPCPs. A midday session for both groups was titled, "The Interface of Psychiatry and Primary Care: Where are we and where do we need to be?" The audience was comprised of 65 local Hawaii psychiatrists in the morning and a group of 46 local Hawaii PCPs in the afternoon. Prior to the midday presentation, each group received a copy of the survey about their attitudes regarding the interface of psychiatry and primary care. Respondents were asked to return their surveys as they left the conference. The issues addressed in the survey had not been discussed with the participants in an attempt to limit bias. There was no coercion or compensation for completing the surveys and the only time limit was that dictated by the length of the conference. Of 111 total physicians present, 38% completed surveys (45% of the psychiatrists and 28% of thePCPs).

Materials

The surveys consisted of six multiple choice questions that were identical for each group except that for the psychiatrists the questions were phrased to query their attitudes regarding medical problems in their patients or their relation toPCPs. The PCP's version was similarly focused on psychiatrists and psychiatric problems in their patients. The specific questions were: 1) Approximately how often do you interact? a. one time per week, b. one time per month, c. several times per year, d. almost never. 2) What proportion of your patients' (medical/psychiatric) problems do you feel comfortable dealing with? a. all, b. most, c. few, d. none. 3) At this time how would you characterize your communication with (psychiatrist/ PCP)? a. excellent/ very helpful b. moderate/ of some value, c. poor/ of little to no value. 4) In your view, difficulties in communication result from: a. time constraints, b. unavailability c. variation in overall approach to patient, d. lack of overlap in areas of professional emphasis, e. other. 5) If screening guidelines or decision tree algorithms were developed for mental illness diagnosis and treatment how would you describe your attitude? a. would welcome their development and use them often, b. envision there role as limited but useful to interface management, c. believe they would be restrictive, time consuming and of little value. 6) Where do you see the main area of interface in the future? a. prevention: refining screening instruments and decision tree algorithms to improve patient care, b. health maintenance: collaboration on chronic conditions with both somatic and psychiatric issues, c. complicated or resistant cases: referral relationship, d. no area of interface. Table 1 summarizes the responses to the specific questions.

Results

Chi square analyses were performed to determine if there were differences in the responses chosen for psychiatrists vs. PCPs (see Table 1). For each of Questions 1, 2, 3, and 5, a two-way chi square test was conducted (i.e., type of subject [psychiatrist vs.PCPs] by multiple choices available). Significant chi square values were obtained for Questions 1, 2, and 5. For Questions 4 and 6, a relatively high proportion of participants endorsed more than one choice per question. Conducting a single chi square on all of the multiple choices within a question would violate the assumption of independence, and therefore, a separate chi square analysis was performed for each choice. Two of the eight comparisons were statistically significant. Overall then, statistically significant differences were found between psychiatrists and PCPs on 5 of the 6 questions (1, 2, 5, and parts of 4 and 6). Question three which dealt with rating communication between the two groups found that both groups felt communication is of excellent or moderate quality with a small minority rating the communication as poor.

From the first question a difference was found in the quantitative degree to which the two groups described their level of interaction ($p<.04$). Psychiatrists chose the option denoting one time per week nearly 70% of the time versus only 23% of the PCPs interacting with psychiatrists this frequently. Nearly 40% of the PCPs interacted on a "several times per year" basis compared to just over 20% of the psychiatrists. The second question revealed that PCPs felt comfortable dealing with nearly 85% of their patients' psychiatric problems while 60% of the psychiatrists chose either few or none as describing their comfort dealing with their patients' medical problems ($p<.04$). Question 4 pointed out that significantly more PCPs (50%) considered unavailability as an impediment to communication as compared to psychiatrists (17.2%, $p<.04$). Psychiatrists were most likely to see time constraints as a barrier to interaction (65.5%). In the "other" option, psychiatrists pointed to "managed care," "lack of interest and education," and "lack of their own group's focus on presenting specific information to primary care doctors" as reasons for communication problems. PCPs wrote of deficiencies in the quality or quantity of consultation reports as impediments to communication with psychiatrists. The fifth question showed that PCPs were more likely (53.9%) to see the role of screening instruments and algorithms as helpful and felt that they would use them often ($p=.05$). Psychiatrists (75.5%) chose the option that described the tools as "limited in value but helpful to interspecialty management." On the last question a significant difference was found between the two groups with psychiatrists (78.6%) foreseeing the interface between the two groups as focusing mainly on the area of health maintenance (collaboration with PCPs on cases with somatic and psychiatric issues, $p<.04$). PCPs (46.2%) chose that option only as often as they chose the other options on prevention or referral. No responding provider thought that there would be "no area of interface" between the two groups in the future.

Discussion

This study suggests clear-cut, if preliminary differences between psychiatrists and PCPs regarding their attitudes towards areas of interface.

Regarding the first aim of this study, in contrast to urgings for psychiatrists to incorporate more primary care duties into their field,[5] the results of this survey would indicate that psychiatrists feel uncomfortable in dealing with most of their patients' medical problems. The boundaries of psychiatrists' roles have been reviewed by other authors[8] and a call has been made for both additional primary care duties in psychiatry[5] and more subspecialization of existing psychiatric disciplines.[8] Other reviews that see the role of psychiatry more appropriately focused on consultative care[9] are more consistent with the attitudes of the psychiatrists responding to this survey. Integration of primary care into psychiatry, based on these results, will more reasonably be attained by further exploration of innovative training programs for a subgroup of primary care psychiatrists as outlined by other authors,[6] rather than imposing primary care duties on practicing psychiatrists.

Though psychiatrists may be uncomfortable with the trend to generalize, PCPs in this survey, on the other hand, seem comfortable with this imposed development. This finding should be contrasted with the inadequate record for diagnosis and management of mental disorders such as depression and anxiety in primary care settings.[10] Although political or economic pressures may outline boundary crossings for each group, our study points out that these initiatives may or may not reflect practitioners' comfort levels.

Concerning the study's second aim, both groups agreed that the quality of communication between them was moderate to excellent. PCPs however, were not satisfied by the amount of communication with psychiatrists, describing them as unavailable. Psychiatrists blamed "time constraints" as an impediment to expedient communication. These findings suggest that if communication between the two groups is to be improved in the future, strategies for more

Table 1—. Frequencies, Percents, 95% Confidence Intervals, and Statistical Test Results on an Attitude Questionnaire on Interfacing and Collaboration Between Psychiatrists and Primary Care Physicians

Survey Questions and Choices	Psychiatrists Freq.	Psychiatrists Percent	Psychiatrists Confidence Interval	Primary Care Physicians Freq.	Primary Care Physicians Percent	Primary Care Physicians Confidence Interval
1. Approximately how often do you interact (collaboratively or in consultation) with [Primary Care Physicians / Psychiatrists]?						
a. One time per week	19	67.9%	49.3-82.1%	3	23.1%	8.2-50.3%
b. One time per month	2	7.1%	2.0-22.6%	2	15.4%	4.3-42.2%
c. Several times per year	6	21.4%	10.2-39.5%	5	38.5%	17.7-64.5%
d. Almost never	1	3.6%	0.6-17.7%	3	23.1%	8.2-50.3%
[x^2= 8.4; df = 3; p < .04]						
2. What proportion of your patient's [medical / psychiatric] problems do you feel comfortable dealing with?						
a. all	1	3.6%	0.6-17.7%	0	0.0%	0.0-22.8%
b. most	10	35.7%	20.7-54.2%	11	84.6%	57.8-95.7%
c. few	14	50.0%	32.6-67.4%	2	15.4%	4.3-42.2%
d. none	3	10.7%	3.7-27.2%	0	0.0%	0.0-22.8%
[x^2 = 8.7; df = 3; p < .04]						
3. At this time how would you characterize your communication with [Primary Care Physicians / Psychiatrists]?						
a. excellent/very helpful to patient management	16	57.1%	39.1-73.5%	5	38.5%	17.7-64.5%
b. moderate/of some limited value	11	39.3%	23.6-57.6%	6	46.2%	23.2-70.9%
c. poor/of little to no value	1	3.6%	0.6-17.7%	2	15.4%	4.3-42.2%
[x^2 = 2.4; df = 2; ns]						
4. In your view, difficulties in communicating with [Primary Care Physicians / Psychiatrists] result from:						
a. time constraints [x^2 = 2.0; df = 1; ns]	19	65.5%	47.3-80.1%	5	41.7%	19.3-68.0%
b. unavailability [x^2 = 4.6; df = 1; p < .04]	5	17.2%	7.6-34.5%	6	50.0%	25.4-74.6%
c. variation in overall approach to patient [x^2 = 1.8; df = 1; ns]	4	13.8%	5.5-30.6%	0	0.0%	0.0-24.3%
d. lack of overlap in areas of professional emphasis [x^2 = 0.1; df = 1; ns]	4	13.8%	5.5-30.6%	2	16.7%	4.7-44.8%
e. other [x^2 = 0.2; df = 1; ns]	4	13.8%	5.5-30.6%	1	8.3%	1.5-35.4%
5. If screening guidelines or decision tree algorithms were developed for mental illness diagnosis and treatment how would you describe your attitude?						
a. would welcome their development and use them often	5	17.9%	7.9-35.6%	7	53.9%	29.1-76.8%
b. envision their role as limited but useful to aid interspecialty management	21	75.0%	56.6-87.3%	6	46.2%	23.2-70.9%
c. believe they would be restrictive, time consuming and of little value [x^2 = 6.0; df = 2; p = .05]	2	7.1%	2.0-22.6%	0	0.0%	0.0-22.8%
6. Where do you see the main area of interface between Primary Care and Psychiatry in the future?						
a. prevention: refining screeening instruments and decision tree algorithms to improve patient outcomes [x^2 = 2.6; df = 1; ns]	6	21.4%	10.2-39.5%	6	46.2%	23.2-70.9%
b. health maintenance: collaboration on chronic conditions with both somatic and psychiatric issues [x^2 = 4.3; df = 1; p<.04]	22	78.6%	60.5-89.8%	6	46.2%	23.2-70.9%
c. complicated or resistant cases: referral relationship [x^2 = 0.2; df = 1; ns]	13	46.4%	29.5-64.2%	7	53.9%	29.1-76.8%
d. no area of interface [x^2 = na]	0	0.0%	0.0-12.1%	0	0.0%	0.0-22.8%

Note: The sum of the percentages per group for Questions 4 and 6 are greater than 100% because some subjects selected more than one choice.
ns = not signiticant.
na = not applicable.
n = 28 for psychiatrists, except for Question 4 where n = 29.
n = 13 for primary care physicians, except for Question 4 where n = 12.

efficient interaction such as the multifaceted collaboration model used for depression[11] should receive further study.

Our studies last aim on the future of interfacing addressed the problem of missed and mistreated psychiatric illness in primary care. There has been support for the use of screening instruments and treatment algorithms in primary care setting.[10] This survey shows that psychiatrists are less enthusiastic about their development and use than are primary care doctors. Traditional differences in interview style (rapid "checklist" screening in primary care versus comprehensive interviewing in psychiatry) may underlie this difference in attitudes. Psychiatrists have traditionally embraced the role of teacher and consultant of mental health issues to PCPs.[12] Being out-of-step with PCPs' needs and expectations would surely limit psychiatrists' ability to act in this capacity.

The results of this study are, of course, limited by the small sample size, the low rate of response to the survey, especially byPCPs, and the selected sample of participants at a conference on the pharmacotherapy of depression. In addition the construction of the survey instrument is weakened by the bias in question and answer choice inherent in a psychiatrist being the author. The questions were based on issues and findings still being studied in recent literature.[6,14,15,16] The focus of inquiries was meant to clarify the nature of interactions between psychiatrists and primary care physicians and how their attitudes, expectations and methods of communication (standardized instruments such as screening tools or algorithms as one example) can effect service delivery. In construction of any future survey to a wider audience, input from primary care physicians to refine the question and answer choices would be helpful. The attitudes expressed by the physicians at this conference may not be representative of the groups of psychiatrists or PCPs on the whole. There is however existing data that supports our finding that PCPs feel comfortable with the management of mental illness as part of their scope of practice.[13] In future surveys of practitioners on this topic, fruitful areas of pursuit might include: commonly seen diagnoses that each group feels comfortable or uncomfortable managing, perceived practical models of collaboration given existing time constraints and specific information about how and how often screening instruments and/or algorithms are being used.

A calling can be heard in these findings for psychiatrists to be more vocal about their practice preferences, continue to work towards more effective communication with our colleagues in primary care and become more involved in the development of mental health treatments provided by other practitioners. If we can generalize at all from the above, it is imperative that the differing attitudes be studied further, in light of the changing roles and expectations that lie ahead for each group. The information gained from these pursuits will hopefully help bring about a smooth transition at the interface of psychiatry and primary care without compromising patient care or practitioner job satisfaction.

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